Adult Day Health Care Services

Definition: Adult Day Health services are furnished 5 or more hours per day on a regularly scheduled basis for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. This service is provided to individuals who are eighteen (18) or older. The objective of this service is to restore, maintain, and promote the health status of an individual through the provision of ambulatory health care and health-related supportive services. Physical, occupational and speech therapies indicated in the individual's plan are not furnished as component parts of this service, but may be provided by enrolled physical, occupational, and/or speech therapy providers at the Adult Day Health Care Center as separate services.

Providers: Centers/agencies enrolled with SCDHHS to provide Adult Day Health Care Services under the Community Supports Waiver. These centers/agencies are listed on the Adult Day Health Provider Listing or you may contact your supervisor if you have questions about a center's/agency's enrollment status.

Once it is determined that Adult Day Health services are needed, you should document the need for the services in the individual's plan and provide the individual or his/her family with the listing of enrolled providers. You should assist the family as needed or requested in choosing a provider and document that you offered a choice of providers.

Prior to starting the service or at the time the service begins, you must provide the Adult Day Health center/agency with a **physician's order** for the service (**Community Supports Form AD-15**), a physical examination report dated not more than 60 days prior to the date services begin, and the physician's recommendations regarding limitations of activities, special diet and medications. (see **Community Supports Form AD-15**).

Once the amount and frequency of the service has been determined and the family has selected a provider, the chosen provider should be contacted to determine space/service availability. Also, at this point, budget information can be entered into the Waiver Tracking System (S79).

Once approved, you can authorize the service. For Adult Day Health Care, one unit equals one "individual day" which is a minimum of 5 hours per day excluding transportation time. If the individual's condition so warrants, a "individual day" may be less than 5 hours. If the individual requires less than 5 hours per day, the total hours per day must be noted on the **Community Supports Form AD-23**. The **Community Supports Form AD-23** must be used to authorize the service. The **Community Supports Form AD-23** instructs the provider to bill Medicaid for services rendered.

Once the center/agency receives the completed **Community Supports Form AD-23** the center or agency must negotiate the start date with you. The **Community Supports Form AD-23** will remain in effect until a new form changing the authorization is provided to the Adult Day Health Care agency or until services are terminated.

Monitoring the Services: You must monitor the effectiveness, frequency, duration, benefits, and usefulness of the service along with the individual's/family's satisfaction with the service (refer to Chapter 9 "Monitorship of Community Supports Waiver Services"). Information gathered during monitoring may lead to a change in the service, such as an increase/decrease in units authorized, change of provider, change to a more appropriate service, etc. The following schedule should be followed when monitoring Adult Day Health Care Services:

- Must complete on-site monitorship during the first month while the service is being provided

- At least once during the second month of service
- At least quarterly thereafter
- Yearly on-site monitorship required

This monitoring will be considered complete when **one or more** of the following has been conducted:

- Review of documentation of services provided for the purpose of assessing the effectiveness, frequency, duration, benefits, and usefulness of the service (i.e. review of progress notes submitted by a psychologist providing psychological services)

- Conversation/discussion with the recipient, recipient's family/caregiver, or Day staff member for the purpose of determining the effectiveness, frequency, duration, benefits, and usefulness of the service.

- Conversation with the service provider about the effectiveness, frequency, duration, benefits, and usefulness of the service.

- On-site observation of the service being rendered for the purpose of determining the effectiveness, frequency, duration, benefits, and usefulness of the service.

Some items to consider during monitorship include:

→ Is the individual satisfied with the Adult Day Health Care Center?
→ Is the ADHC Center clean (sanitary)?
→ Is the ADHC Center in good repair?
→ How often does the individual attend? If less than five hours a day, is this authorized?
→ Are there any health/safety issues?
→ Is PT, OT, or Speech therapy needed?
→ How often does the ADHC Center Staff have contact with family?
→ Are there any behavior problems?
→ What type of recreational activities does the person participate in?
→ What types of recreational activities does the ADHC Center offer?
→ Does the individual feel comfortable interacting with staff?
→ What are the opportunities for choice given to the individual?
→ What type of care is the individual receiving?

Reduction, Suspension, or Termination of Services: If services are to be reduced, suspended, or terminated, a written notice must be forwarded to the individual or his/her legal guardian including the details regarding the change(s) in service, allowance for appeal, and a ten (10) calendar day waiting period before proceeding with the reduction, suspension, or termination of the waiver service(s). See **Chapter 8** for specific details and procedures regarding written notification and the appeal/reconsideration process.

S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

COMMUNITY SUPPORTS WAIVER

PHYSICIAN'S ORDER
FOR
ADULT DAY HEALTH SERVICES

Individual's Name: _____

Date of Birth: _____

SSN: | | | | | | | | | |

I hereby order Adult Day Health Services to be provided to the above named person with the following limitations of activities: _____

This person requires the following diet: _____

This person requires the following medication: _____

A physical examination report must be attached.

Physician's Name Telephone #

Address

Physician's Signature Date

NOTE: Must be completed within 60 days of admission to ADHC.

S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
COMMUNITY SUPPORTS WAIVER

AUTHORIZATION FOR SERVICES
TO BE BILLED TO SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

TO: _____

_____

RE: _____
Individual's Name / Date of Birth

_____
Address

Medicaid # _____

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Prior Authorization # **C S** _____

Adult Day Health Care Services (X6987)

Number of Units Per Week :_____ one unit = 1 (5 hour) day

Start Date:_____

OR

The above named individual cannot tolerate a 5 hour day. Therefore you are authorized to provide:
Number of Units Per Week :_____ (one unit = _____ hours per day)
Start Date:_____

Service coordinator: Name / Address / Phone # (Please Print):

_____

_____

_____ _____
Signature of Person Authorizing Services Date

COMMUNITY SUPPORTS Form AD-23

MEDICAID HOME AND COMMUNITY-BASED WAIVER

SCOPE OF SERVICES
FOR
ADULT DAY HEALTH CARE SERVICES

A. Objective

The objective of Adult Day Health Care (ADHC) Services is to restore, maintain, and promote the health status of Medicaid home and community-based waiver individuals through the provision of ambulatory health care and health-related supportive services in an ADHC center.

B. Conditions of Participation

1. The ADHC provider must maintain a current Adult Day Care license from the Department of Health and Environmental Control (DHEC) or equivalent licensing agency for an out-of-state provider.

2. Agencies of ADHC services must agree to participate in all components of the Care Call monitoring and payment services.

C. Description of Services to Be Provided

1. The Unit of Service will be a CLTC individual-day of ADHC services consisting of a minimum of five (5) hours at the center. The five (5) hours does not include transportation time. The unit of Service will be a minimum of four (4) hours when the individual has a medical appointment requiring him or her to leave early or arrive late. The Case Manager/Service Coordinator must be notified within two (2) working days when an individual arrived late or left early due to a medical appointment. For individuals authorized under the Community Supports (CSW) waiver, the individual-day may be four (4) hours or more, if the individual's condition so warrants and the provider is advised accordingly on the DDSN service authorization.

2. The ADHC center must be open Monday through Friday at least eight hours a day. The hours of operation may be any eight hours between 7:00 am and 6:00 pm. The Provider shall annually, between September 1– September 30, provide to SCDHHS, Division of CLTC a list of regularly scheduled holidays and the Provider shall not be required to furnish services on those days. A copy of this list will be posted in a visible location at the day care center. Any deviation in hours or days of operation during the contract period requires prior approval by the Department Head of Provider Relations and Compliance, Division of CLTC Waiver Management.

3. The number of days an individual attends each week is determined through the Medicaid home and community-based waiver service plan and indicated on the service authorization.

4. The Provider must either provide directly, or make sub-contractual arrangements, for some but not all of the following non-billable services which are included in the daily rate:

   a. Daily Nursing Services performed by an RN or under the supervision of an RN as permissible under State law to monitor vital signs as needed; to observe the functional level of the individual and note any changes in the physical condition of each individual; to supervise the administration of medications and observe for possible reactions; to teach positive health measures and encourage self-care; to coordinate treatment plans with the physician, therapist, and other involved service delivery agencies; to supervise the development and implementation of a care plan; to appropriately report to the individual's physician and/or the Case Manager/Service Coordinator any changes in the individual's condition. Documentation of service provision must be approved by the RN.

   b. Supervision of, Assistance with and Training in Personal Care and Activities of Daily Living including dressing, personal hygiene, grooming, bathing and maintenance of clothing.

   c. Daily Planned Therapeutic Activities to stimulate mental activity, communication and self-expression. These include reality orientation exercises, crafts, music, educational and cultural programs, games, etc.

   d. One Meal and a Snack per day with the meal meeting 1/3 of the daily recommended dietary allowances (RDA) for this age group as adopted by United States Department of Agriculture. Special diets prescribed by the attending physician must be planned and prepared with consultation from a registered dietitian as needed.

   e. Individual Transportation to and from the center must be provided by the Provider for all individuals–who reside within fifteen (15) miles of the center using the most direct route, door to door, from the center to the individual's place of residence or other location as agreed to by the provider and as indicated on the service authorization. The mode of transportation must be an enclosed vehicle with adequate ventilation, heat, air conditioning, and provision for wheelchair bound individuals as needed.

      Providers who are directly providing transportation to individuals will provide assistance to the individual from the door of the individual's residence to the vehicle and from the vehicle to the door of the individual's residence or other location as agreed to by the provider and as indicated on the service authorization.

5. The Provider will incorporate in the procedures for operation of the center adequate safeguards to protect the health and safety of the individuals in the event of a medical or other emergency.

D. Staffing

1. The minimum staff requirements must be consistent with licensing requirements (one direct-care staff for every eight individuals). In addition to the minimum staffing standards required by licensing, whenever home and community-based waiver individuals are present the following staffing standards for nurses and case managers apply. All nurse staffing and care must be provided within the scope of the South Carolina Nurse Practice Act. Should the RN position become vacant, the ADHC Provider must notify the local CLTC office no later than the next business day. Any deviations from these staffing patterns must be approved in writing by the (SCDHHS), Director, Division of CLTC Waiver Management.

For 1-44 home and community-based waiver ADHC individuals: one RN must be present as follows:

1 – 10 individuals	2 hours minimum
11 – 20 individuals	3 hours minimum
21 – 25 individuals	4 hours minimum
26 – 35 individuals	5 hours minimum
36 – 44 individuals	6 hours minimum

For 45 – 88 home and community-based waiver ADHC individuals: one RN and one additional RN or LPN must be present for a minimum of five hours whenever home and community-based waiver individuals are present. At least one nurse must be present at all times the center is open.

For 89 - 133 home and community-based waiver ADHC individuals:

a. one RN and two additional RNs or LPNs; or
b. one RN, one additional RN or LPN and one case manager.

Required nursing and case management staff must be present for a minimum of five hours whenever home and community-based waiver individuals are present. At least one nurse must be present at all times the center is open.

For 134 - or more home and community-based waiver ADHC individuals:

c. one RN and three additional RNs or LPNs; or,
d. one RN, and two additional RNs or LPNs and one case manager.

Required nursing and case management staff must be present for a minimum of five hours whenever home and community-based waiver individuals are present. At least one nurse must be present at all times the center is open.

2. The ADHC provider must have on staff a Nursing Supervisor with the following qualifications:

a. Registered Nurse (RN) currently licensed by the S.C. State Board of Nursing or by a state that participates in the nursing compact, or by an appropriate licensing authority of the state in which the ADHC provider is located for an out-of-state provider; and

b. Minimum of one year experience in a related health or social services program; and

c. Minimum of one year administrative or supervisory experience.

3. For ADHC providers with 89 or more home and community based waiver individuals who employ a case manager to meet staffing requirements of section D. 3 and D.4, the case manager must have a bachelor's degree in health or human science with case management study.

4. Aides working at the ADHC must meet minimum staffing requirements consistent with licensing requirements**.**

5. Drivers employed by ADHC who transport home and community-based waiver individuals must have a valid drivers license and be certified in first aid.

6. PPD Tuberculin Test

No more than ninety (90) days prior to employment, all staff having direct individual contact shall have a PPD tuberculin skin test, unless a previously positive reaction can be documented. The two-step procedure is advisable for initial testing in those who are new employees in order to establish a reliable baseline. [If the reaction to the first test is classified as negative, a second test should be given one to three weeks after the first test. If the second test is classified as negative, the person is considered as being uninfected. A positive reaction to a third test (with an increase of more than 10mm) in such a person within the next few years, is likely to represent the occurrence of infection with M. Tuberculosis in the interval. If the reaction to the second of the initial two tests is positive, this probably represents a boosted reaction, and the person should be considered as being infected.]

In lieu of a PPD tuberculin test no more than 90 days prior to employment, a new employee may provide certification of a negative tuberculin skin test within the 12 months preceding the date of employment and certification from a licensed physician or local health department TB staff that s/he is free of the disease.

Employees with reactions of 10mm and over to the pre-employment tuberculin test, those with newly converted skin tests, and those with symptoms suggestive of tuberculosis (e.g., cough, weight loss, night sweats, fever, etc.) regardless of skin test status, shall be given a chest radiograph to determine whether tuberculosis disease is present. If tuberculosis is diagnosed, appropriate treatment

must be given, and the person must not be allowed to work until declared non-contagious by a licensed physician.

Routine chest radiographs are not required on employees who are asymptomatic with negative tuberculin skin tests.

Employees with negative tuberculin skin tests shall have an annual tuberculin skin test.

New employees who have a history of tuberculosis disease and have had adequate treatment shall be required to have certification by a licensed physician or local health department TB staff (prior to employment and annually) that they are not contagious. Regular employees who are known or suspected to have tuberculosis shall be required to be evaluated by a licensed physician or local health department TB staff, and must not return to work until they have been declared non-contagious.

Preventive treatment should be considered for all infected employees having direct individual contact who are skin test positive but show no symptoms of tuberculosis. Routine annual chest radiographs are not a substitute for preventive treatment. Employees who complete treatment, either for disease or infection, are exempt from further routine radiographic screening, unless they develop symptoms of tuberculosis. Employees who do not complete adequate preventive therapy should have an annual assessment for symptoms of tuberculosis.

Post exposure skin tests should be provided for tuberculin negative employees within twelve (12) weeks after termination of contact to a documented case of infection.

Providers needing additional information should contact the Tuberculosis Control Division, Department of Health and Environmental Control, 1751 Calhoun Street, Columbia, S.C. 29201 (phone (803) 898-0685.

7. Personnel Records

Provider must maintain individual personnel records, for each employee, including contracted personnel, which document the qualifications necessary to meet part C.4 and D of this contract.

E. Conduct of Services

The provider must maintain documentation showing that it has complied with the requirements of this section.

1. The Case Manager/Service Coordinator will request ADHC services by authorizing the amount, duration and frequency of service for individuals in accordance with the individual's needs. Services must be provided as authorized.

2. The Case Manager/Service Coordinator will obtain the signed and dated physician's order for ADHC and a physical examination report (SCDHHS Form #122) that is not over sixty (60) days old. The report must include recommendations regarding limitations of activities, special diet, and medications. This will be sent to the provider prior to or at the time of admission to ADHC. Subsequent physical examinations or periodic health screening to determine the individual's ability to continue in the program will be required at least every two years. These must contain the same elements as the initial physical examination report. The ADHC Provider will be responsible for procuring the subsequent physical examination reports.

3. The Case Manager/Service Coordinator will notify the Provider immediately if an individual becomes medically ineligible for Medicaid home and community-based waiver services. The Case Manager/Service Coordinator will make every effort to verify Medicaid eligibility on a monthly basis. However, the Provider should refer to the language in the Community Long Term Care Services Provider Manual regarding the provider's responsibility in checking the individual's Medicaid card.

4. The Case Manager/Service Coordinator will review an individual's needs within two (2) working days of receipt of a written request from the Provider to modify the CLTC Service Plan/DDSN Service Authorization.

5. Providers must have a daily schedule/activity plan that provides for the delivery of all required services to all individuals.

6. The Provider will develop and maintain a Policy and Procedure Manual which describes how activities will be performed in accordance with the terms of the contract.

7. The Provider will maintain a daily attendance log documenting the arrival and departure times of each individual and staff member. A separate log will be maintained indicating staff in attendance and arrival and departure times.

In addition, the provider must maintain an individual individual record that documents the following items:

8. The Provider will initiate ADHC services on the date negotiated with the Case Manager/Service Coordinator and indicated on the Medicaid home and community-based waiver authorization. The case manager/service coordinator must be notified should services not be initiated on that date. Services provided prior to the Medicaid authorization date are not reimbursable.

9. The Provider will notify the Case Manager/Service Coordinator within two (2) working days of the following individual changes:

   a. Individual's condition has changed or the individual no longer appears to need ADHC services.

   b. Individual is institutionalized, dies or moves out of service area.

   c. Individual no longer wishes to participate in ADHC services.

   d. Knowledge of the individual's Medicaid ineligibility or potential ineligibility.

   e. Individual does not attend the day care on an authorized day and provider has not been notified of reason for absence.

10. The Provider will maintain a record keeping system which establishes an individual profile in support of the units of ADHC services delivered, based on the Medicaid home and community-based waiver authorization. Individual individual records must be maintained and contain the Medicaid home and community-based waiver authorization, the ADHC's care plan (which is approved and signed by the RN), the Medicaid home and community-based waiver CLTC Mode of Transportation form, the Physician Orders (DHHS Form 122), and daily documentation of all care and services provided. In addition, for CLTC authorized services, the ADHC care plan must be based on the CLTC Service Plan and the CLTC Service Plan must be maintained in the individual record.

F. Administrative Requirements

1. The Provider agency shall designate an individual to serve as the agency administrator. This does not have to be a full time position; however, the designated administrator must have the authority and responsibility for the direction of the Provider agency. The Provider agency shall notify SCDHHS within three working days in the event of a change in the agency Administrator, address, or telephone number.

2. The organization, administrative control and lines of authority for the delegation of responsibility down to the hands-on individual care level staff shall be set forth in writing. This shall be readily accessible to all staff and shall include an organizational chart. A copy of this shall be forwarded to SCDHHS at the time the contract is implemented. Any future revisions or modifications shall be distributed to all staff of the Provider agency and to SCDHHS.

3. The Provider agency must have written bylaws or equivalent which are defined as "a set of rules adopted by the Provider agency for governing the agency's operations." Such bylaws or equivalent shall be made readily available to staff of the Provider agency and shall be provided to SCDHHS upon request.

4. Administrative and supervisory functions shall not be delegated to another agency or organization.

5. A governing body or designated persons so functioning shall assume full legal authority for the operation of the Provider agency. A listing of the members of the governing body shall be made available to SCDHHS upon request.

6. An annual operating budget, including all anticipated revenue and expenses related to items which would under generally accepted accounting principles be considered revenue and expense items, must be submitted to SCDHHS prior to the signing of the initial contract with SCDHHS. The Provider agency must maintain an annual operating budget which shall be made available to SCDHHS upon request.

7. The Provider agency shall acquire and maintain during the life of the contract liability insurance and worker's compensation insurance to protect all paid and volunteer staff, including board members, from liability and/or injury incurred while acting on behalf of the agency. The Provider agency shall furnish annually, between September 1 – September 30, copies of the insurance policies to SCDHHS.

Effective July 1, 2007